Part V

Incidents and Investigations: Policies, Procedures and Forms

PROVIDER MANUAL
FOR
COMMUNITY MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES AND
ADDICTIVE DISEASES
PROVIDERS
FOR
THE DIVISION OF MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES AND
ADDICTIVE DISEASES

JULY 2006

Georgia Department of Human Resources **Division of Mental Health, Developmental Disabilities and Addictive Diseases**	POLICY NO: 2.101
Applicability: • State Hospitals • Public and Private community providers • OTP & State-operated community programs • State MHDDAD office • Regional MHDDAD offices	REFERENCE: Official Code of Georgia 37-1-2; 37-1-20; 37-2-1 et seq.; 37-3-166; 37-3-2; 37-4-125; 37-4-3; 37-7-166; 37-7-2; 30-5-1 et seq.; 19-7-5; 16-6-5.1; DHR Rules and Regulations for Patients' Rights, Chapters 290-4-6; DHR Rules and Regulations for Clients' Rights 290-4-9.
SUBJECT: Reporting of Consumer Deaths and Critical Incidents	**Effective date: July 1, 2005** **Scheduled Review Date: May 23, 2006**
Attachments: A-Critical Incident Definitions B-Critical Incident Report C-Reporting to other Agencies	**APPROVED:** **- signed -** **Gwendolyn B. Skinner, Director MHDDAD**

I. POLICY

It is the policy of the Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) to maintain a safe and humane environment for consumers, and to prevent abuse, neglect and exploitation of consumers. The DMHDDAD uses a standardized process for reporting deaths and critical incidents that involve consumers being served by the DMHDDAD in state hospitals and community providers.

II. DEFINITIONS

Category I Incidents: Unexplained or suspicious deaths (including suicides), allegations of physical abuse, allegations of neglect, allegations of sexual assault/exploitation, medication errors with adverse consequences, consumer to consumer assault resulting in injury requiring treatment beyond first aid, seclusion/restraint resulting in injury requiring treatment beyond first aid (See Attachment A).

Category II Incidents: Deaths (other than unexplained or suspicious), allegations of verbal abuse, allegation of financial exploitation, consumer who leaves the grounds of a state hospital without permission, consumer who is unexpectedly absent from a community residential program, medical hospitalization of a consumer of a state hospital or community residential program, consumer injury requiring treatment beyond first aid, seclusion or restraint resulting in injury requiring minor first aid, consumer-to-consumer assaults or incidents with injury requiring minor first aid, vehicular accidents with injury while consumer is in a state vehicle or is being transported by community or hospital staff, incident occurring at a providers site which required intervention of law enforcement services, criminal conduct by consumer (See Attachment A).

Community Provider: Any person or entity providing community-based disability services through a contract with or authorized by the DMHDDAD and/or providing Medicaid services authorized by DMHDDAD. "Community Provider" includes any state owned or operated community program. For purposes of this policy, community provider includes services provided through a subcontractor. "Community Provider" does not include state hospital inpatient care units, nor does it include private community providers who do not have a contract, Memorandum of Understanding, Letter of Agreement or service authorization with the state to provide DMHDDAD services.

Consumer: An individual enrolled with a community provider for disability services, seeking services or admission at a state hospital, or on the census of a state hospital. The terms "client" or "patient" are used interchangeably with consumer.

Critical Incident: Any event that involves an immediate threat to the care, health or safety of any consumer in community residential services, on site with a community provider or hospital, in the company of a staff member of a community provider or hospital, or absent without leave from inpatient or residential services. Critical incidents include, but are not limited to, all deaths as defined and all incidents as listed in categories I and II.

Critical Incident Database: DMHDDAD web-based system for entering data about critical incidences.

Deaths: The death of any consumer in a community residential service, on the census of a state hospital, on site with a community provider or hospital, in the company of staff of a community provider or hospital, or absent without leave from inpatient or residential services. Deaths include suicides and the death of a consumer occurring within two (2) weeks following the consumer's discharge from a state hospital or community residential provider AND the death of any consumer transferred or discharged to a medical facility for treatment of any illness or injury that occurred during hospital or community provider supervision, regardless of the time that has elapsed since the transfer or discharge.

Disability Services: Direct services to an individual, or services, which are designed to prevent or ameliorate the effect of a disability.

Exploitation: The illegal or improper use of an individual's labor, property or resources for another's profit or advantage and/or the failure to accurately account for the consumer's funds by a payee.

High-Visibility Incident: Critical incidents as defined in this policy, which have system-wide impact, have impact upon, or relevance to, any ongoing litigation of DHR or DMHDDAD, or may have significant impact upon, or significant relevance to, issues of DHR or DMHDDAD public concern and/or are likely to be reported in the media.

Neglect: An act or omission by any individual or organization responsible for providing services that creates a significant risk of injury or death to a consumer.

Physical Abuse: The willful infliction of physical pain, physical injury, or unreasonable confinement. For purposes of this policy, "willful" means other than accidental.

Senior Executive Manager: The supervisor administratively in charge at the time of the incident.

Sexual Assault/Exploitation: Any sexual contact between an employee and a consumer. Includes the solicitation of a consumer by an employee for sexual purposes.

State Hospital: A state Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) hospital facility.

Unexplained or Suspicious Death: A death not related to a known condition and that may have resulted from an act of omission or commission while receiving care from a DMHDDAD provider. This includes suicides.

Verbal Abuse: The use of words or gestures by an employee to threaten, coerce, intimidate, harass or humiliate a consumer.

III. PROCEDURES

A. Reporting deaths

1. Upon discovery of a death of a consumer, the state hospitals/community providers immediately take any actions necessary to protect other consumers' health, safety and rights. These actions may include:

   - Immediate and ongoing medical attention, as appropriate;
   - Suspension or reassignment of an employee from a position involving direct care pending the outcome of any investigation; and

- Other measures to protect the health, safety and rights of other consumers, as necessary.

2. Upon discovery of the death of a consumer, the state hospital/community provider:

   - Immediately calls local law enforcement and the coroner/medical examiner if law enforcement has not called the coroner/medical examiner;
   - Calls the guardian, if any, and/or next of kin of the deceased after authorization from the coroner/medical examiner;
   - In the case of a child's death in a state hospital, designates a staff person, who is qualified to provide crisis/grief counseling, to notify the parent/guardian in person of the death;
   - Notifies the support coordinator, if applicable, within 24 hours; and
   - In instances when DFACS, DJJ, or APS has custodial or commitment responsibility, notifies the worker within 24 hours.

3. The state hospital/community provider immediately reports by phone all unexplained or suspicious deaths to the Investigations Section. This call must be made as soon as possible, but at least within two (2) hours of the death. The provider should present any information available at the time of the telephone report that is required on the *Critical Incident Report* form (Attachment B). A copy of the *Critical Incident Report* form must be submitted on the same day as the consumer's death, or on the next business day if the death occurred after business hours or on a weekend or holiday. The senior executive manager is responsible for ensuring that both the telephone notification and the written *Critical Incident Report* are submitted as required. In the case of state hospitals, this is the responsibility of the Regional Hospital Administrator.

4. For all unexplained or suspicious deaths, the Investigations Section notifies the Director of MHDDAD, the Division Medical Director and the Regional Coordinator immediately.

5. When there is suspicion that a crime has been committed in a state hospital, the Investigations Section consults with the Division Director prior to contacting the Georgia Bureau of Investigation (GBI).

6. For all other consumer deaths, the state hospital/community provider transmits, by fax or electronically, the *Critical Incident Report* form (Attachment B) to the Investigations Section. The report must be submitted on the same day as the consumer's death or on the next business day if the death occurred after business hours or on a weekend or holiday.

7. The DMHDDAD Medical Director serves as consultant to the Investigations Section as needed.

8. The state hospital/community provider requests that the coroner/medical examiner conduct an autopsy and provides sufficient facts to the coroner/medical examiner regarding the death.

9. In the event that the coroner/medical examiner decides not to perform an autopsy, the state hospital/community provider ensures that the coroner/medical examiner's decision is documented, and if known, the rationale for the decision.

10. For consumer deaths that must be reported to other agencies or offices as required by law or regulation, the state hospital/community provider is responsible at all times for notifying such agencies and offices in a timely manner. (See Attachment C)

B. Reporting all other Category I and II Critical Incidents (excluding deaths)

1. Upon discovery of a Category I critical incident other than death, state hospitals/community providers immediately take any action necessary to protect consumers' health, safety and rights. These actions may include:

   - Contacting 911 or other emergency services as needed;
   - Immediate and ongoing medical attention, as appropriate;
   - Removal of an employee from direct contact when the employee is alleged to have been involved in abuse or neglect until such time as the state hospital/community provider has sufficiently determined that such removal is no longer necessary; and
   - Other measures to protect the health, safety and rights of the individual, as necessary.

2. The state hospital/community provider immediately calls:

   - Local law enforcement and the Investigations Section if there is reasonable suspicion that a crime has been committed; and
   - The consumer's guardian and/or next of kin, as appropriate with respect to confidentiality regulations.

3. When there is suspicion that a crime has been committed in a state hospital, the Investigations Section consults with the Division Director prior to contacting the GBI.

4. The state hospital/community provider immediately reports all Category I critical incidents to the Regional Hospital Administrator/community provider administrator.

5. The state hospital/community provider immediately reports by phone all high visibility Category I and II critical incidents to the Investigations Section. This call must be made as soon as possible, but at least within two (2) hours of the high visibility incident. A *Critical Incident Report* form (Attachment B) must be submitted on the same day as the high visibility incident or on the next business day if the incident occurred after business hours or on a weekend or holiday.

6. For high visibility incidents, the Investigations Section notifies the Director of MHDDAD, the Regional Coordinator, and the Department of Human Resources (DHR) Office of Communications.

7. For all other Category I critical incidents, the state hospital/community provider transmits, by fax or electronically, the *Critical Incident Report* form (Attachment B) to the Investigations Section on the same day as the Category I incident, or on the next business day if the incident occurred after business hours or on a weekend or holiday.

8. For all other Category II critical incidents, The *Critical Incident Report* (Attachment B) is faxed or electronically sent to the Investigations Section within 24 hours of the incident or on the next business day if the incident occurred after business hours or on a weekend or holiday.

9. When a consumer has an assigned support coordinator, the state hospital/community provider reports the Category I or II critical incident by telephone to the support coordinator within 24 hours.

10. For Category I and II critical incidents that must be reported to other agencies or offices as required by law or regulation, the state hospital/community provider is responsible at all times for notifying such agencies and offices in a timely manner (See Attachment C).

C. Reports of Incidents by persons other than staff of state hospitals or community provider

1. Consumers, family members of consumers, support coordinators or any other persons may initiate reports of critical incidents as needed.

2. Upon discovery of incidents not already reported by the state hospital/community provider, support coordinators report the incidents in accordance with procedures outlined in section III., B.

3. When information about a critical incident is received by a state hospital/community from any person other than support coordinators, the staff receiving the information completes the *Critical Incident Report* form and follows procedures outlined in section III., B.

4. When information about a critical incident is received by the Investigations Section, the staff receiving the information completes the *Critical Incident Report* form.

D. Administrative Review of *Critical Incident Report* form

1. State hospitals/community providers perform an administrative review of all *Critical Incident Reports*. The administrative review includes, at a minimum:

- Reading the *Critical Incident Report*;
- Reading all statements and reports associated with the incident;
- Requiring and ensuring the completion of any incomplete or missing documentation; and
- Signing as the administrative reviewer on the *Critical Incident Report* form.

2. For state hospitals, the Regional Hospital Administrator or designated executive staff conducts the administrative review of all *Critical Incident Report* forms (Attachment B).

3. For community providers (including state-operated community programs), the provider defines in their internal policy the supervisory staff appropriate and available to perform the administrative review of all *Critical Incident Report* forms.

4. The Investigations Section reviews all *Critical Incident Reports* for completeness and contacts the state hospital/community provider for changes and additional information, as appropriate.

5. The Investigations Section in all cases obtains a copy of the death certificate from the Division of Public Health. This copy may not be reproduced or released outside the Division of MHDDAD.

E. Computer data entry

1. DMHDDAD maintains a consumer death and critical incident database to identify patterns and to perform trend analyses.

2. Each state hospital/community provider designates one or more persons to be responsible for entering critical incident and death information into the database. Entries must be made within two (2) business days of the event or knowledge of the event.

3. The Investigations Section enters critical incidents and death information received from the community providers into the database.

F. Investigations of Critical Incidents

1. The Investigations Section conducts investigations of all Category I critical incidents, in accordance with the Investigating Consumer Deaths and Critical Incidents policy, 2.201. If the Investigations Section determines that the provider should conduct the investigation, the provider is notified within three (3) hours of receipt of the initial report.

2. State hospitals and community providers conduct investigations of Category II critical incidents, in accordance with the Investigating Consumer Deaths and Critical Incidents policy, 2.201.

G. Procedures for Data Analysis

1. The deaths and critical incidents reporting processes are monitored by the Investigations Section to include:

   - Entry of all Critical Incident Reports into the database;
   - Timeliness of Critical Incident Reports entered into the database; and
   - Patterns of critical incidents occurring in state hospitals/community providers.

2. State hospitals/community providers have procedures for analyzing incident patterns. Incidents include the following:

   - Incidents not required to be reported by this policy utilized for internal quality improvement programs; and
   - Incidents reported through this policy.

3. Information about incidents is utilized by the Division's Quality Improvement program to evaluate the quality of services.

Georgia Department of Human Resources **Division of Mental Health, Developmental Disabilities and Addictive Diseases**	POLICY NO: 2.201
Applicability: • State Hospitals • Public and Private community providers • OTP & State-operated community programs • State MHDDAD office • Regional MHDDAD offices	REFERENCE: Official Code of Georgia 37-1-2; 37-1-20; 37-2-1 et seq.; 37-3-166; 37-3-2; 37-4-125; 37-4-3; 37-7-166; 37-7-2; 30-5-1 et seq.; 19-7-5; 16-6-5.1; DHR Rules and Regulations for Patients' Rights, Chapters 290-4-6; DHR Rules and Regulations for Clients' Rights 290-4-9.
SUBJECT: Investigating Consumer Deaths and Critical Incidents	Effective date: **July 1, 2005** **Scheduled Review Date: May 23, 2006**
Attachments: A-Protocol for Investigations B-Final Investigative Report Format C-Review of Final Investigative Report form D-Request for Extension E-Corrective Action Plan	**APPROVED:** **- signed -** **Gwendolyn B. Skinner, Director MHDDAD**

I. POLICY

It is the policy of the Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) to maintain a safe and humane environment for consumers, and to prevent abuse, neglect and exploitation of consumers. The DMHDDAD uses a standardized process for investigation of critical incidents and deaths that involve consumers being served by the DMHDDAD in state hospitals and community providers.

II. DEFINITIONS

Category I Incidents: Unexplained or suspicious deaths (including suicides), allegations of physical abuse, allegations of neglect, allegations of sexual assault/exploitation, medication errors with adverse consequences, consumer to consumer assault resulting in injury requiring treatment beyond first aid, seclusion/restraint resulting in injury requiring treatment beyond first aid.

Category II Incidents: Deaths (other than unexplained or suspicious), allegations of verbal abuse, allegation of financial exploitation, consumer who leaves the grounds of a state hospital without permission, consumer who is unexpectedly absent from a community residential program, medical hospitalization of a consumer of a state hospital or community residential program, consumer injury requiring treatment beyond first aid, seclusion or restraint resulting in injury requiring minor first aid, consumer-to-consumer assaults or incidents with injury requiring minor first aid, vehicular accidents with injury while consumer is in a state vehicle or is being transported by community or hospital staff, incident occurring at a providers site which required intervention of law enforcement services, criminal conduct by consumer.

Community Provider: Any person or entity providing community-based disability services through a contract with or authorized by the DMHDDAD and/or providing Medicaid services authorized by DMHDDAD. "Community Provider" includes any state owned or operated community program. For purposes of this policy, community provider includes services provided through a subcontractor. "Community Provider" does not include state hospital inpatient care units, nor does it include private community providers who do not have a contract, Memorandum of Understanding, Letter of Agreement or service authorization with the state to provide DMHDDAD services.

Consumer: An individual enrolled with a community provider for disability services, seeking services or admission at a state hospital, or on the census of a state hospital. The terms "client" or "patient" are used interchangeably with consumer.

Corrective Action Plan: A document which identifies and analyzes problems within the provider organization and prescribes corrective action steps which, when implemented, are likely to prevent the recurrence of similar problems and improve the quality of consumer care. A corrective action plan must identify the person(s) responsible for ensuring that action steps are completed and reviewed for efficacy and establishes a schedule for completion and follow-up of all action steps.

Critical Incident: Any event that involves an immediate threat to the care, health or safety of any consumer in community residential services, on site with a community provider or hospital, in the company of a staff member of a community provider or hospital, or absent without leave from inpatient or residential services. Critical incidents include, but are not limited to, all deaths as defined and all incidents as listed in categories I and II.

Critical Incident Database: DMHDDAD web-based system for entering data about deaths and critical incidences.

Deaths: The death of any consumer in a community residential service, on the census of a state hospital, on site with a community provider or hospital, in the company of staff of a community provider or hospital, or absent without leave from inpatient or residential services. Deaths include suicides and the death of a consumer occurring within two (2) weeks following the consumer's discharge from a state hospital or community residential provider AND the death of any consumer transferred or discharged to a medical facility for treatment of any illness or injury that occurred during hospital or community provider supervision, regardless of the time that has elapsed since the transfer or discharge.

Disability Services: Direct services to an individual, or services, which are designed to prevent or ameliorate the effect of a disability.

Exploitation: The illegal or improper use of an individual's labor, property or resources for another's profit or advantage and/or the failure to accurately account for the consumer's funds by a payee.

Final Investigative Report: A written summary of an investigation conducted by the Investigation Section, state hospitals or community providers of an alleged critical incident or death.

High-Visibility Incident: Critical incidents as defined in this policy, which have system-wide impact, have impact upon, or relevance to, any ongoing litigation of DHR or DMHDDAD, or may have significant impact upon, or significant relevance to, issues of DHR or DMHDDAD public concern and/or are likely to be reported in the media.

Investigator: A trained staff person who is designated to perform investigations into critical incidents.

Neglect: An act or omission by any individual or organization responsible for providing services that creates a significant risk of injury or death to a consumer.

Physical Abuse: The willful infliction of physical pain, physical injury, or unreasonable confinement. For purposes of this policy, "willful" means other than accidental.

Sexual Assault/Exploitation: Any sexual contact between an employee and a consumer. Includes the solicitation of a consumer by an employee for sexual purposes.

State Hospital: A state Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) hospital facility.

Unexplained or Suspicious Death: A death not related to a known medical condition and that may have resulted from an act of omission or commission while receiving care from a DMHDDAD provider. This includes suicides.

Verbal Abuse: The use of words or gestures by an employee to threaten, coerce, intimidate, harass or humiliate a consumer.

III. PROCEDURES

A. Investigation of unexplained or suspicious deaths

1. The Investigations Section conducts all investigations of unexplained and suspicious deaths.

2. The investigation includes:

- Interviewing consumers, staff and other involved parties;
- Reviewing all related documentation; and
- Collaborating with outside agencies, as applicable.

3. All investigations completed by the Investigations Section must be thorough and must address, at a minimum, those items identified in the *Protocol for Investigations* (Attachment A).

4. If, at any time during the investigation, evidence of criminal conduct is discovered, the Investigations Section immediately notifies the Director of DMHDDAD and law enforcement authorities.

5. If law enforcement authorities initiate an investigation into the death of a consumer, the state hospital/community provider staff cooperate with the investigators.

6. If, at any time during an investigation, it appears that a community provider or its staff has failed to protect the health, safety and/or welfare of the consumers in its care, the Investigations Section requests that the Regional Coordinator take immediate steps to protect such consumers, including the removal of the consumer(s) to another community provider, if needed. The Regional Coordinator, or his/her designee, notifies the Investigations Section of actions taken.

7. The Investigations Section completes its *Final Investigative Report* (Attachment B) for all unexplained or suspicious deaths within thirty (30) calendar days following the date of the death or discovery of the death.

8. The Investigations Section requests a copy of the consumer's death certificate from the Division of Public Health. This copy may not be reproduced or released outside the Division of MHDDAD. If the cause of death differs from the report submitted by the state hospital/community provider, the case is reopened and the DMHDDAD Medical Director is notified to review the case.

9. The Investigations Section distributes a Draft *Final Investigative Report* for review to the Division Director, Assistant Division Director of Program Development and Operations, Medical Director, and Legal Services. The reviews (Attachment C) are given to the Investigations Section within seven (7) calendar days of receipt. A summary of the reviews is distributed to the Division Director who provides final approval of the *Final Investigative Report* within 14 calendar days of receipt.

10. If there is a compelling reason why the Investigations Section cannot complete the investigation within thirty (30) days, a *Request for Extension* form (Attachment D) must be filled out and submitted to the Division Director outlining the reasons and giving an expected completion date. Such requests must be received by the Division Director at least five (5) calendar days prior to report due date. The Division Director may establish a new deadline, not to exceed thirty (30) calendar days.

11. The Investigations Section delivers the *Final Investigative Report* to the Director of Regional Operations within three (3) calendar days of completion of the report. The Director of Regional Operations distributes the *Final Investigative Report* to the state hospital/community providers and Regional Coordinator.

B. Investigation of all other deaths

1. The state hospital/community provider designates qualified staff, who has been trained to do investigations, to conduct investigations of all other deaths.

2. The investigation includes:

- Interviewing consumers, staff and other involved parties;
- Reviewing all related documentation; and
- Collaborating with outside agencies, as applicable.

3. All investigations completed by the state hospital/community provider are thorough and must address, at a minimum, those items identified in the *Protocol for Investigations* (Attachment A).

4. If, at any time during the investigation, evidence of criminal conduct is discovered, the state hospital/community provider immediately notifies law enforcement authorities and notifies the Investigations Section.

5. If law enforcement authorities initiate an investigation into the death of a consumer, the Regional Hospital Administrator (RHA) or community provider administrator ensure that their staffs cooperate with the investigators.

6. If, at any time during an investigation, it appears that the community provider or its staff has failed to protect the health, safety and/or welfare of the consumers in its care, the Regional Coordinator takes immediate steps to protect such consumers, including the removal of the consumer(s) to another community provider, if needed. The Regional Coordinator, or his/her designee, notifies the Investigations Section of actions taken.

7. The state hospital/community provider completes and submits a *Final Investigative Report* (Attachment B) to the Investigations Section. These reports are submitted via fax, mail or electronically within thirty (30) calendar days following the date of the consumer's death or discovery of death.

8. If there is a compelling reason why the state hospital/community provider cannot complete the investigation within thirty (30) days, a *Request for Extension* form (Attachment D) is filled out and submitted to the Investigations Section outlining the reasons and giving an expected completion date. Such requests must be received by the Investigations Section at least five (5) calendar days prior to report due date. The Investigations Section may establish a new deadline, not to exceed thirty (30) calendar days.

9. When state hospitals/community providers receive autopsy reports, a copy is provided to the Investigations Section on the same day of the receipt of the report.

10. The Investigations Section requests a copy of the consumer's death certificate from the Division of Public Health.

C. Investigation of all other Category I and II critical incidents

1. The Investigations Section investigates all Category I critical incidents, unless the Investigations Section determines that the provider should conduct the investigation. This determination is made within 3 hours of receipt of the initial report, and is based on the type of incident and the investigation history of the provider.

2. The state hospital/community provider designates qualified staff who are trained to do investigations to investigate all Category II critical incidents.

3. The investigation includes, at minimum:

   - Interviewing consumers, staff and other involved parties;
   - Reviewing all related documentation; and
   - Collaborating with outside agencies, as applicable.

4. All investigations completed are thorough and must address, at a minimum, those items identified in the *Protocol for Investigations* (Attachment A).

5. If, at any time during an investigation, it appears that the community provider or its staff has failed to protect the health, safety and/or welfare of the consumers in its care, the Regional Coordinator takes immediate steps to protect such consumers, including the removal of the consumer(s) to another community provider, if needed. The Regional Coordinator, or his/her designee, informs the Investigations Section of actions taken.

6. If, at any time during the investigation, evidence of criminal conduct is discovered, the investigator immediately notifies law enforcement authorities.

7. If law enforcement authorities initiate an investigation into a critical incident of a consumer, state hospital/community provider staff cooperate with the investigation.

8. The results of investigations of the following incidents involving the following residents are reported to the Regional Hospital Administrator within five (5) working days of the incident:

   - Skilled nursing facilities- Allegations of abuse, neglect or exploitation; injuries of unknown origin; misappropriation of resident property; or
   - ICF/MR-Allegation of abuse or neglect with injury requiring treatment beyond first aid; time-out or restraint resulting in injury requiring treatment beyond first aid; death not related to course of illness or underlying condition; allegation of rape or sexual assault.

9. The investigator completes and submits a *Final Investigative Report* within thirty (30) calendar days following the date of the incident or discovery of the incident to the Investigations Section.

10. If there is a compelling reason why the investigation cannot be completed within thirty (30) days, a *Request for Extension* form (Attachment D) is filled out and submitted to the Investigations Section outlining the reasons and giving an expected completion date. Such requests are received by the Investigations Section at least five (5) calendar days prior to report due date. The Investigations Section may establish a new deadline, not to exceed thirty (30) calendar days.

11. The Investigations Section delivers the *Final Investigative Report* to the Director of Regional Operations within three (3) calendar days of completion of the report. The Director of Regional Operations distributes the *Final Investigative Report* to the state hospital/community provider and Regional Coordinator.

D. Administrative Review

1. State hospitals/community providers perform a review of all the *Final Investigative Reports* completed by the state hospital/community provider. The review includes, at a minimum:

   - Reading the *Final Investigative Report*;
   - Reading all accompanying documentation;
   - Requiring and ensuring the completion of any incomplete or missing documentation; and
   - Signing off as the administrative reviewer on the *Final Investigative Report*.

2. The Investigations Section reviews all *Final Investigative Reports* completed by state hospital/community providers for content, thoroughness of the investigation, and demonstration that conclusions were based on the evidence available. The review includes, at a minimum:

   - Reading the *Final Investigative Report*;
   - Reading all accompanying documentation;
   - Requiring and ensuring the completion of any incomplete or missing documentation; and
   - Completing the *Review of Final Investigative* Report form (Attachment C).

3. For Final Investigative Reports completed by the state hospital/community provider that are deemed inadequate, the Investigations Section returns the report to the state hospital/community provider for corrections. The state hospital/community provider has three (3) business days to complete and return the Final Investigative Report with corrections.

4. The Director of Investigations or his/her designee reviews all *Final Investigative Reports* completed by the Investigations Section. The review includes, at a minimum:

   - Reading the *Final Investigative Report*;
   - Reading all accompanying documentation;
   - Requiring and ensuring the completion of any incomplete or missing documentation; and
   - Signing off as the administrative reviewer on the *Final Investigative Report*.

5. The Division Medical Director conducts and documents a review of all consumer death files.

E. Corrective Action Plans and follow-up

1. Upon completion and review of *Final Investigative Report* the Investigations Section notifies the state hospital/community provider of the need for a Corrective Action Plan (CAP). The Regional Coordinator is also notified.

2. A CAP (Attachment E) must be submitted to the Investigations Section for all critical incidents where problematic issues were noted within 14 calendar days of notice from the Investigations Section.

3. The Investigations Section accepts or makes recommendations for changes to the CAP with input from the Regional Coordinator. The Regional Coordinator is responsible for follow-up to ensure that all corrections are made.

4. For CAPs that are not completed successfully by contracted providers, the Regional Coordinator coordinates appropriate contract actions with DMHDDAD Legal Services.

F. Computer Data Entry

1. DMHDDAD maintains a consumer death and critical incident database in order to identify patterns and to perform trend analyses.

2. Each state facility designates one or more persons to be responsible for entering the Final Investigative Report deadline into the database.

3. The Investigations Section enters the date the Final Investigative Report was received from the state/hospital community providers into the database.

Part V

APPENDICES for
Incidents and Investigations

Critical Incident Definitions, by Category

Category	Incident Type	Definition
I	Unexplained/Suspicious Death	The **suspicious** death of any consumer in a community residential program, on the census of a state hospital, on site with a community provider or hospital, in the company of staff of a community provider or hospital, or absent without leave from inpatient or residential services. This may include the death of a consumer occurring within two (2) weeks following the consumer's discharge from a state hospital or community residential provider AND the death of any consumer transferred or discharged to a medical facility for treatment of any illness or injury that occurred during hospital or community provider custody, regardless of the time that has elapsed since the transfer or discharge. A suspicious death is a death that is not related to a known medical condition and could be attributed to abuse or neglect.
I	Physical abuse	The willful infliction of physical pain, physical injury, or unreasonable confinement. For purposes of this policy, "willful" means other than accidental. Does not include sexual assault or exploitation. Does not include approved physical interventions when appropriately utilized.
I	Neglect	The failure of an employee or an organization to provide goods and services necessary to avoid physical harm, mental anguish or mental illness or creates a significant risk of injury or death to a consumer.
I	Sexual assault/exploitation	Any sexual contact between an employee and a consumer. Includes the solicitation of a consumer by an employee for sexual purposes.

I	Medication errors with adverse consequences	Medication error includes omission and wrong dose, time, person, medication, route, position, technique/method and form. Adverse consequences are those that cause the consumer discomfort or jeopardizes his/her health and safety. Does not include refusal of medication by consumer.
I	Consumer-to-consumer assaults or incidents with injury requiring treatment beyond first aid	The injury received is severe enough to require the treatment of a consumer by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to warrant or require hospitalization; further, the treatment received may be provided within the facility or provided outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a general acute care hospital. This includes any forced sexual activity between consumers.
I	Seclusion or restraint resulting in injury requiring treatment beyond first aid	Seclusion or restraint includes physical holding, as well as mechanical restraints, and time-out. This would not include postural supports or restraints for medical or surgical procedures. Injury includes any physical harm or damage that requires treatment beyond first aid or more serious treatment. Note: This would include any injury, regardless of severity.
II	Death	The expected or explained death of any consumer in a community residential service, on the census of a state hospital, on site with a community provider or hospital, in the company of staff of a community provider or hospital, or absent without leave from inpatient or residential services. Deaths include the death of a consumer occurring within two (2) weeks following the consumer's discharge from a state hospital or community residential provider AND the death of any consumer transferred or discharged to a medical facility for treatment of any illness or injury that occurred during hospital or community provider custody, regardless of the time that has elapsed since the transfer or discharge. This does not include Suspicious Deaths in Category I.

II	Verbal abuse	The use of words or gestures by an employee to threaten, coerce, intimidate, harass or humiliate a consumer
II	Allegation of Financial exploitation	The illegal or improper use of an individual's labor, property or resources for another's profit or advantage.
II	Consumer who leaves the grounds of state hospital without permission.	Reportable events include (1) consumer is absent from a designated location and cannot be found w/in the hospital campus and (2) consumer who is off campus but under direct observation of hospital staff (e.g., appointment, recreational activity, being transported to/from such appointments and activities) is absent from the designated location. Not included are events where consumer is not under supervision of hospital staff and fails to return to designated location at designated time (i.e., failure to return from authorized leave).
II	Consumer unexpectedly absent from a community residential program	Consumer who has left the residence without knowledge of staff and whose location is not known. Would include all absences where law enforcement is notified.
II	Medical hospitalization of a consumer of a state hospital or community residential program	Any emergency admission to a medical facility, either directly or through the facility's emergency room. Would not include planned admissions, such as for elective surgery.
II	Consumer injury requiring treatment beyond first aid	Includes accidents; does not include illness. The injury received is severe enough to require the treatment of a consumer by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to warrant or require hospitalization; further, the treatment received may be provided within the facility or provided outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a general acute care hospital

II	Seclusion or restraint resulting in injury requiring minor first aid	Seclusion or restraint includes physical holding, as well as mechanical restraints, and time-out. This would not include postural supports or restraints for medical or surgical procedures. Injury includes any physical harm or damage that requires minor first aid. Minor first aid is meant to include treatments such as the application of band-aids/steri strips/dermabond, cleaning of abrasions, application of ice pack for minor bruises, and use of OTC medications such as antibiotic creams, aspirin and acetaminophen.
II	Consumer-to-consumer assaults or incidents with injury requiring minor first aid	Assaults or incidents occurring at the provider site or while in the company of provider staff. Minor first aid is meant to include treatments such as the application of band-aids/steri strips/dermabond, cleaning of abrasions, application of ice pack for minor bruises, and use of OTC medications such as antibiotic creams, aspirin and acetaminophen.
II	Vehicular accidents with injury while consumer is in a state vehicle or is being transported by community or hospital staff	The injury should require treatment beyond minor first aid. Minor first aid is meant to include treatments such as the application of band-aids/steri strips/dermabond, cleaning of abrasions, application of ice pack for minor bruises, and use of OTC medications such as antibiotic creams, aspirin and acetaminophen.
II	Incident occurring at provider site which requires intervention of law enforcement services	Includes 911 calls from staff for assistance, as well as reports to law enforcement of theft of consumer property by employees or non-employees while at the provider site or accompanied by staff.
II	Criminal conduct by consumer	Conduct while on the site of the provider or when accompanied by staff. Would also include criminal conduct of a consumer who leaves the grounds of a state hospital without permission and a consumer who is unexpectedly absent from a community residential program.

Incidents to report to other agencies, in addition to MHDDAD[1]

Consumer Group	Incidents(s) to Report	Report to whom?	Timeframe
Disabled adults in personal care homes or CLAs	Death of a resident; rape of resident; allegation of abuse, neglect or exploitation	ORS-Long Term Care Section	24 hours, or the next business day
Children in outdoor therapeutic programs	Death or serious injury (requiring extensive medical care and/or hospitalization of any camper in care); suicide attempts; abuse	ORS-Childcare Licensing Section Fax form to ORS	48 hours, or the next working day
Persons residing in skilled nursing facilities	Allegations of abuse, neglect or exploitation; injuries of unknown origin; misappropriation of resident property	ORS-Long Term Care Fax form to ORS	Report within 24 hours For Medicaid-participating nursing homes, results of investigations must be reported within 5 working days
Persons in hospital	Unanticipated death not related to natural course or underlying disease; allegation of rape or sexual assault	ORS-Health Care Section Fax form to ORS	Within 24 hours of next business day
Persons in ICF/MR	Allegation of abuse or neglect with injury requiring treatment beyond first aid; time-out or restraint resulting in injury requiring treatment beyond first aid; death not related to course of illness or underlying condition; allegation of rape or sexual assault	ORS-Health Care Section Fax form to ORS	Within 24 hours or next business day
Disabled adult or elder person in the community or outside of a nursing home, personal care home or community living/group home	Abuse or neglect and danger is not immediate	Call Adult Protective Services 1-888-774-0152	Immediately or next business day
Child under the age of 18	Abuse or neglect	Local law enforcement and/or/ local DFCS office	Immediately notify law enforcement if there is immediate danger
Persons in narcotic treatment program	Death; serious injury at program requiring medical care; rape occurring at program; abuse, neglect or exploitation of patient by	ORS	Within 24 hours or next business day

	staff; emergency situation that affects safe operation of program		

[1]This is only a summary. The reader must obtain detailed instructions and definitions directly from the responsible agency.

DHR-MHDDAD Policy 2.101
Attachment B

Incident #

CRITICAL INCIDENT REPORT FORM

Date of Report: _____ Date of Incident/Death: _____

Date of Discovery of Incident/death: _____ Time of Incident/Death: _____

State Hospital/Community Provider reporting: _____

If reporting provider is a subcontractor, who is primary contractor?: _____

Contact Person: _____ Contact Person phone # _____

MHDDAD Region: _____

Consumer(s) Information

Name _____ DOB _____ Age at time of incident _____ Sex _____

Address _____ City _____ State GA Zip _____ County _____

Medicaid Waiver? Yes ☐ No ☐ MHID # _____ SS# _____ Race _____

Disability: MH ☐ DD ☐ AD ☐ Dual Diagnosis ☐ Specify _____

Briefly describe services provided to consumer: _____

Name _____ DOB _____ Age at time of incident _____ Sex _____

Address _____ City _____ State GA Zip _____ County _____

Medicaid Waiver? Yes ☐ No ☐ MHID # _____ SS# _____ Race _____

Disability: MH ☐ DD ☐ AD ☐ Dual Diagnosis ☐ Specify _____

Briefly describe services provided to consumer: _____

Name _____ DOB _____ Age at time of incident _____ Sex _____

Address _____ City _____ State GA Zip _____ County _____

Medicaid Waiver? Yes ☐ No ☐ MHID # _____ SS# _____ Race _____

Disability: MH ☐ DD ☐ AD ☐ Dual Diagnosis ☐ Specify _____

Briefly describe services provided to consumer:

Witnesses to Incident

Name: _____ Contact # _____ Staff ☐ Consumer ☐ Other ☐

Name: _____ Contact # _____ Staff ☐ Consumer ☐ Other ☐

Name: _____ Contact # _____ Staff ☐ Consumer ☐ Other ☐

Name: _____ Contact # _____ Staff ☐ Consumer ☐ Other ☐

Name: _____ Contact # _____ Staff ☐ Consumer ☐ Other ☐

Name: _____ Contact # _____ Staff ☐ Consumer ☐ Other ☐

Name: _____ Contact # _____ Staff ☐ Consumer ☐ Other ☐

Name: _____ Contact # _____ Staff ☐ Consumer ☐ Other ☐

Type of Incident

Category I *(check all that apply)* **Check here if incident is high visibility** ☐

- ☐ Unexplained/suspicious death *(please complete death section)*
- ☐ Allegation of physical abuse
- ☐ Allegation of neglect
- ☐ Allegation of sexual assault/exploitation
- ☐ Consumer-consumer assault resulting in injury requiring treatment beyond first aid
- ☐ Medication errors with adverse consequences
- ☐ Seclusion/restraint resulting in injury requiring treatment beyond first aid

Category II *(check all that apply)* **Check here if incident is high visibility** ☐

- ☐ Death (other than unexplained/suspicious) *(please complete death section)*
- ☐ Allegation of verbal abuse
- ☐ Allegation of financial exploitation
- ☐ Consumer who leaves the grounds of a state hospital without permission
- ☐ Consumer who is unexpectedly absent from a community residential program
- ☐ Medical hospitalization of a consumer of a state hospital or community residential program
- ☐ Consumer injury requiring treatment beyond first aid
- ☐ Seclusion/restraint resulting in injury requiring minor first aid
- ☐ Consumer-to-consumer assaults or incidents with injury requiring minor first aid
- ☐ Vehicular accident with injury while consumer is in a state vehicle or is being transported by community/hospital staff
- ☐ Incident occurring at a providers site which required intervention of law enforcement services
- ☐ Criminal conduct by consumer

- ☐ Incident that does not meet Category I or II criteria *(describe below)*

Describe Category I, II or other incident below:

Type of Incident

Category I *(check all that apply)* **Check here if incident is high visibility** ☐

- ☐ Unexplained/suspicious death *(please complete death section)*
- ☐ Allegation of physical abuse
- ☐ Allegation of neglect
- ☐ Allegation of sexual assault/exploitation
- ☐ Consumer-consumer assault resulting in injury requiring treatment beyond first aid
- ☐ Medication errors with adverse consequences
- ☐ Seclusion/restraint resulting in injury requiring treatment beyond first aid

Category II *(check all that apply)* **Check here if incident is high visibility** ☐

- ☐ Death (other than unexplained/suspicious) *(please complete death section)*
- ☐ Allegation of verbal abuse
- ☐ Allegation of financial exploitation
- ☐ Consumer who leaves the grounds of a state hospital without permission
- ☐ Consumer who is unexpectedly absent from a community residential program
- ☐ Medical hospitalization of a consumer of a state hospital or community residential program
- ☐ Consumer injury requiring treatment beyond first aid
- ☐ Seclusion/restraint resulting in injury requiring minor first aid
- ☐ Consumer-to-consumer assaults or incidents with injury requiring minor first aid
- ☐ Vehicular accident with injury while consumer is in a state vehicle or is being transported by community/hospital staff
- ☐ Incident occurring at a providers site which required intervention of law enforcement services
- ☐ Criminal conduct by consumer

- ☐ Incident that does not meet Category I or II criteria *(describe below)*

Describe Category I, II or other incident below:

Deaths (if applicable)

How was death discovered? _____

Date of last contact with consumer _____ Reason for contact _____

Was death expected? ☐ Yes ☐ No Was death an accident? ☐ Yes ☐ No

Possible suicide? ☐ Yes ☐ No Possible Homicide? ☐ Yes ☐ No

Presence of Significant disease processes/factors in death *(check all that apply)*

☐ Aspiration Pneumonia/Pneumonia ☐ Bowel Obstruction ☐ Cancer ☐ Choking ☐ Diabetes ☐ Heart Disease

☐ History of Strokes ☐ Infections ☐ Influenza ☐ Liver Disease ☐ Lung Disease ☐ Medication Related

Has autopsy been ordered? ☐ Yes ☐ No If not, state reason _____

Cause of death, when known _____

Were there unusual circumstances surrounding death? ☐ Yes ☐ No If yes, please describe below

Please list all medications given to the consumer one week prior to the point of death. Add additional pages if necessary.

Name of Medication	Dose/Route/Frequency given

Protocol for Investigations

I. An investigation is a collection of information that will describe and explain an event or series of events. The scope of the investigation will be appropriate to the nature of the incident. For example, some incidents will not require the collection of evidence or witness statements. At a **minimum**, the following procedures regarding investigations are followed:

A. Ensuring that investigations are timely. Make sure investigations begin as soon as possible so that the investigator may, for instance, collect any potential evidence and preserve it and to obtain witness statements while the information is fresh in the minds of the witness(es).
B. Safeguarding confidential information of any consumer(s) at all times.
C. Avoiding conflict(s) of interest. In order for an investigation to be fair, it must be done by an investigator who is impartial; that is, it must be done by a person who has no personal interest in the findings or outcome of the investigation. An investigator may have a conflict of interest under a number of circumstances, including but not limited to: being related by blood, working relationship, or by close friendship to someone who was involved in the incident. If, at any time during an investigation, an actual or apparent conflict of interest arises and/or is discovered, the investigator having the conflict of interest or apparent conflict shall not begin or, if the investigation has already begun, shall cease investigating the incident and shall provide to any newly designated investigator all information collected prior to the discovery of the conflict or apparent conflict.

II. The investigator will collect information, including all available evidence, about the incident and complete and submit a written report to the appropriate individual and/or entity within the time frame specified in Policy # 2.201. A thorough investigation must be conducted and such investigation must follow the guidelines provided in this protocol.

A. What the investigation should determine:

1. Date and time the incident was discovered? Reported?
2. Who is the alleged victim? What services the alleged victim is receiving?
3. The condition of the alleged victim (e.g., has the alleged victim been hospitalized? Is the alleged victim deceased? Is the victim able to provide information about the incident?).
4. Is the alleged victim in need of protective services (is it unsafe for the alleged victim to remain in the current placement or service because of risk of repeated incidents)? If so, refer immediately to the Regional Hospital Administrator or CEO, as appropriate.
5. Where did the incident take place?
6. If a death has occurred, is the coroner or medical examiner of the county conducting an investigation? Date and time of notification.
7. Is law enforcement conducting an investigation? If so, which agency(ies)? Who is the person and/or department to contact for questions and information? Investigations Section, regional offices, hospitals, and their investigator should cooperate with law enforcement appropriately.
8. Who reported the incident? Was this person a participant in or witness to the incident?
9. The chronology of events from the occurrence of the incident to the time of the investigation. Events occurring prior to/contemporaneously with the incident may be included if relevant to the incident and the investigation.

10. All obtainable relevant facts and details about the incident. This includes any document(s) and physical evidence collected, reviewed and identified as bearing any relevance to the investigation. Such documents should include:

    a. Death certificate, if applicable;
    b. Relevant clinical records of the client(s) involved;
    c. Reports and/or investigative material(s) of law enforcement or other entities;
    d. Relevant personnel records of staff involved, if applicable;
    e. Relevant policy and procedure;
    f. Photographs, if necessary, properly labeled;
    g. Accident or similar reports;
    h. Witness statements.

    All evidence must be preserved and the investigator shall make every effort to protect against loss of or damage to evidence.

11. A witness list should include the full names, titles, and work assignment of all persons who were interviewed, gave statements, etc. Consumers should be listed by consumer ID number and address or unit number. The witness list should include brief notes as to the witness' relevance to the case, and the type of statement included, if any.

Example 1:

1.	John Doe, HST Unit 12	Witnessed the alleged abuse (Witness statement and interview statement)
2.	Susan Smith Consumer, Unit 3	Victim – stated she was pushed by _____. (Interview statement)
3.	Alice Johnson, MD Black Co. Hospital	Examined consumer for injuries. (Interview statement and copy of hospital notes).

Example 2:

1.	Mary Jones, title if any Day shift, ABC Personal Care Home	Witnessed consumers fighting (Witness statement and interview statement)
2.	Mary Smith Day treatment coordinator Happytown CSB	Received call reporting the fight (Interview statement)

12. If staff witnessed the incident, include the name(s) and title(s) of staff. When interviewing witnesses, separate the known witnesses to prevent them from speaking with each other about the incident, to the extent possible. The investigator shall collect information from the witnesses about the incident. This includes:

    a. **Who** was involved in the incident? Obtain the person(s) full name(s), title (if staff), shift (if applicable), location at time of incident, work location at time of incident (if staff). Record information about the person who submitted the report, the person(s) who treated the alleged victim.

b. **What** happened? Collect the details about the events.
c. **When** did the incident occur? When was the incident discovered? What routines or activities were going on during the time of the incident?
d. **Where** did the incident occur? Where was the alleged victim? Where was the alleged perpetrator? Where were the witnesses? Where can witnesses be located if not at their place of work? Where was the evidence obtained, marked, stored?
e. **How** was the incident discovered? How was the incident committed, if known? How was the incident reported? How did the alleged victim, witnesses and perpetrator get to the scene of the incident? How were the tools/weapons, if any, used in the event?
f. **Why** did the incident occur? Why were the particular tools used? Were the alleged victim or witnesses cooperative/uncooperative?
g. Are there other persons having knowledge of the incident?

13. There may be a procedure for all staff involved in or witnessing an incident to write a witness statement as soon as possible after the incident occurs, and before the close of that shift or business day, as applicable. Prior to completing their written statement, staff should be separated to prevent them from speaking to each other about the incident, to the extent possible. The witness statement should be hand written by the staff member, dated, timed, and signed. The statement should include the staff member's staff assignment for that shift or duties for that day, the consumers he/she was assigned to, what he/she was doing immediately before the incident began, and what he/she saw, heard, and did regarding the incident. Staff should include the full names of other staff, but may use initials to identify consumers. All such statements should be included in the Final Investigative Report. In addition, all staff should be directed to refrain from discussing the incident with other witnesses or persons involved during the time period of the investigation. Alternatively, witness statements may be obtained after the investigators interview them.

14. When taking interviews, the investigator should remember to exercise judgment in determining which interviews to conduct, transcribe and include within the Final Investigative Report.

- Not all staff needs to be interviewed, only staff whose information is relevant to the investigation.
- Rarely do interviews need to be recorded. As an example, an interview might be recorded if the statement is so long and complicated that it would be difficult to record by hand.
- The most relevant information from some interviews may be captured in an interview statement format, signed and dated by the person who was interviewed.
- Recorded interviews must be transcribed.
- Transcribed interviews should be included within the Investigation Report. Only interviews that are relevant and important to the investigation should be transcribed and placed within the report. If interviews are conducted and recorded, but not transcribed, the tape should be maintained properly for a designated period of time.

Transcribed interviews should include:

- Date of interview;
- Time of interview;

- Name of person being interviewed;
- Name of person conducting the interview;
- Name and title/relationship of all persons present during the interview; and
- Time the interview ended.

15. Recommended order of witness interviews

    a. First – Person who reported the incident.
    Try to clarify the points and confirm that there is truly a matter to investigate before proceeding further.
    b. Second – Alleged Victim.
    If possible, learn from the victim information about what happened, where, when, how, who else was in the area.
    d. Third – Eye Witnesses/Others near the scene.
    It is not always clear at the beginning of the investigation how many witnesses may exist. The alleged victim, other witnesses, schedules or other documentary evidence may provide other leads for the investigator. Every witness must be interviewed in order for the investigation to be considered thorough.
    e. Fourth – Alleged Perpetrator(s).
    The last person(s) to be interviewed is the person who is alleged to have committed the action against the client. By collecting all the other information from the other witnesses and gathering any documents related to the situation, the investigator will have a better opportunity to assess the credibility of that individual who, if guilty, would be the most evasive or resistive to an interview.

    Note: For hospital and other state employees only, DHR Policy #1201, "Standards of Conduct and Ethics in Government," # 2 states: Employees are required to cooperate fully and truthfully and provide assistance when appropriate, with any type of investigation regarding alleged criminal or administrative misconduct. This includes activities such as cooperating with interviews, answering questions related to the performance of official duties, producing requested documents and polygraph examinations.

17. The investigator's final report should conform to the format contained in this policy.

FINAL INVESTIGATIVE REPORT FORMAT

To the User: *This format is used for the summary of an investigation. However, not all of the items listed below will be necessary for all incidents. For example, some incidents will not require the collection of evidence or witness statements. It is the responsibility of the agency to comply with the requirements of Policy 2.201with regard to content. Please consult with the local Investigations Unit staff for questions about specific incidents and investigations.*

Date of Report:

Provider Agency:
Agency Contact: Phone:
Investigating Agency: Investigator:
Date of Investigation: Date of Incident:
MHDDAD Region of Residence: Region of Responsibility:

Consumer Name:
Address:
MHID/CID #: SSN:
Date of Birth: Age at time of incident:

SUMMARY OF ALLEGATION(S)/INCIDENT:

Guidelines

What happened? Who reported it and to Whom was the incident or allegation reported to? Where, When and How was it reported?
(List each allegation or problem area separately.)

INVESTIGATIVE METHODS:

Guidelines
Date and time investigation initiated
What physical, written documents, interviews, witness statements, and evidence was collected and considered?
What agencies were involved with incident?
What agencies were notified of the incident?
What medication(s) were prescribed?
(Consult Appendix A 'Protocol for Investigations" from Investigations policy for further specifics about any section in this report form.)

CHRONOLOGY OF EVENTS:

GUIDELINES

What happened from the time of the immediate precipitating or causal events of the incident or allegation until the time of the investigation? (Date and time each significant event.)
What or who is the source of information?
If occurring at a residential site/group home/program site, when was assistance (such as emergency or administrative) requested?
If the staff was directed to or decided to obtain medical treatment, when was it obtained and, if not obtained immediately, what was the reason for waiting?

If this is a death, include any information available from the coroner or others about the possible cause of death. Also include any information about the consumer's condition prior to death.

SUMMARY OF FINDINGS:

Guidelines
What did the investigation find out from the evidence collected?
What are the facts established about the allegation/incident?
Were there any bias or credibility issues and/or inconsistencies with the reported allegation/incident and the evidence collected and analyzed?
Was staff awareness demonstrated by the timely discovery of the incident, previous training in consumer needs, etc.?

Did staff follow established procedures when responding to the incident?
Has any medical staff of the provider agency reviewed this incident? If so, please provide the name and title of the physician or the name of the committee, e.g., "Robert Jones, M.D., Clinical Director" or "Medical Peer Review Committee."

CONCLUSIONS:

GUIDELINES

Do the findings substantiate or not substantiate the reported allegation/incident?
(List each allegation or problem area, then respond to each separately.)
Could the allegation/incident be substantiated but the cause remains undetermined?
Did staff respond to the incident in a timely and appropriate manner?

AREA(S) OF IMPROVEMENT:

GUIDELINES

What actions can be taken by the provider to make corrections and prevent recurrence?

FOR DEATHS, EXPECTED AND UNEXPECTED:
Please list any of the following procedures that were utilized in the review of this death: review by medical director or other physician, medical peer review, sentinel event

protocol (Joint Commission accredited facilities, only.) Do not attach copies of any peer review documents. Simply state what was done, by whom, and the date.

ATTACHMENTS

Guidelines
List of documents reviewed
List of witnesses (identifying who was interviewed and, if not, the reason for no interview) and status (consumer, staff, family, etc.)

Witness statements
Interview statements
Agency policies & procedures (specifically related to investigation and needed for explanation of the investigative findings)
Photographs
Graphs, charts, maps

Investigated By:

_____ _____
Investigator Signature Date

_____ _____
Agency Director Signature or Designated Hospital Executive Date

Review of Final Investigative Report

Consumer Name:	Incident #:
Reviewer Name/title:	Region:

☐ **Based on my review, the following additional information is required:**

_____
_____
_____
_____
_____
_____
_____
_____

☐ **Based on my review, the investigation is complete.**

_____ _____

Reviewer Signature **Date**

Request for Extension of Due Date for Final Report

Instructions: Complete the form below (please type the information) and fax to the Investigations Unit at (404) 657-2187. For state hospitals, the request must be signed by the Regional Hospital Administrator. For contracted community providers, the request must be signed by a responsible executive manager.

Date of Request:

Consumer(s) Name:

Date of Incident:

Provider Agency Name:

Reason(s) for the request:

Expected completion date:

_____ _____

Printed Name/Title of Responsible Person Signature

Corrective Action Plan

Provider Name:	Incident #:		Date of Plan:	
Issue	Identified Problem	Corrective Steps	Target Date	Responsible Person